

Warwickshire Safeguarding Children Board 12th August 2015

Response to 'John' SCR.

WSCB commissioned two SCIE accredited independent safeguarding consultants to undertake an SCR in respect of 'John', a young, premature infant who died unexpectedly on the first night his family were staying with extended family after being evicted from their social housing tenancy.

The review used the SCIE 'Learning Together methodology for conducting reviews, which engages throughout with practitioners and senior managers from the agencies involved with the case being reviewed. This engagement enables emerging learning to be taken back to agencies throughout the process.

After receiving the review report, which makes five findings, WSCB held a meeting on 2nd June to discuss the report, review what actions had already been taken in response to the findings, and identify further action to be taken either on a single or multi-agency basis. This report summarises the information shared by partner agencies at this meeting, and sets further activity planned by the partnership in response to the review.

Finding One: In Warwickshire the lack of understanding by professionals across all agencies of both the impact of eviction on a family and the eviction process increases the chance that children in these circumstances will be left vulnerable.

A briefing note has been prepared by the housing association which housed the family explaining the legal process followed by social landlords when rent is not paid, which has eviction as its final stage. This is being circulated widely amongst frontline staff, and will be used in training to ensure that practitioners are aware of how they can support families to make arrangements that would avoid eviction, and to ensure that they understand that a family having children does not prevent landlords evicting if there is no apparent prospect of rent being paid. Public Health will be able to host this information on their new online portal.

A variety of arrangements are being made to ensure assessment processes consider the stability of housing arrangements as well as suitability, including statutory social work assessments, Youth Justice Asset assessment, health visiting antenatal home visits, CAF (common assessment framework) assessments completed by the Priority Families service and probation offender managers delivering 1-1 work with offenders. Staff have been reminded that they must test what they are being told by parents, for example social workers have been encouraged to seek permission to make direct contact with the housing provider,

and Youth Justice practitioners will speak to parents about housing as well as the young person they are assessing.

Local Authority Housing teams have re-arranged their services to put a stronger emphasis on early intervention to assist families at risk of eviction. This has included promoting the use of CAF to structure assessment and intervention.

The housing association has begun holding an internal case conference involving all officers involved with a family before eviction to ensure all relevant information held by the organisation is considered, and if eviction is progressed this information will be shared with children's social care in a referral. Some new roles have been created which are able to work proactively in the community with tenants at risk of losing their homes, and the relevant housing authority will also be notified. All staff have revisited their safeguarding training.

WSCB is leading a piece of work (initiated as a result of other learning and improvement activity) to develop a shared understanding amongst partner agencies and other service providers in Warwickshire about the language of 'referral', 'contact' and 'notification' to ensure that it is clear whether the sharing of information between agencies is expected to result in action.

WSCB will ask the housing authorities in Warwickshire to align their processes so that it is clearer for other housing providers how to engage with local authority homeless prevention services, and explore whether the arrangements that support social housing tenants at risk of eviction can be extended to private tenants.

The independent chair will write to the courts which consider bailiff warrant applications for Warwickshire tenants to ask how they consider the vulnerability of children in these households.

Finding Two: In Warwickshire there are underlying indicators that suggest agencies' responses can be superficial and do not always get to the heart of what the issues are, and therefore do not fully address risk.

A previous case review conducted by WSCB identified the need to support practitioners to cultivate 'professional curiosity and respectful uncertainty'. As a result of this, it is planned that the next WSCB conference will have this theme.

WSCB has developed a training course called 'Making and Taking referrals' to support conversations between referrers and duty social workers which pull out what it is known about the family and jointly explore appropriate next steps. This aims to support a shared understanding of the thresholds for early help and social care services, and provide support to universal service providers when early help is the right level of service.

Partner agencies have taken a range of approaches to supporting staff to look at cases in the round. Some of these (such as checking information shared by parents, more use of face to face visits by housing staff to families at risk of eviction,) are addressed under finding one above. Additionally a number of agencies including children's social care, community

health and the Community Rehabilitation Company are giving increased focus to the way that professional supervision provides challenge, and support for critical thinking.

WSCB will develop a policy on the supervision of staff who work with children to provide a structure for this important quality assurance and practice support function, and to promote supervision as a tool to stimulate professional curiosity and respectful uncertainty.

WSCB will develop a neglect toolkit that supports deeper assessment and analysis in neglect cases.

Finding three: In Warwickshire until social care complete their assessment there is no formal multi-agency plan and social care do not see their role as coordinator of services during the assessment period.

WSCB will undertake a piece of work to agree with partners how the statutory requirement set out in Working Together 2015 which states that when a referral is accepted a children's social worker becomes the lead professional (pp28-29) is interpreted locally, and embedded in Warwickshire's multi-agency procedures.

Finding four: A wealth of experience and expertise with this rapid response multiagency team enables a pattern of effective rapid response in this team. However there is not sufficient capacity in the system to ensure that an equally effective response is made to all unexpected child deaths of Warwickshire children.

The CDOP manager has provided detailed data identifying the circumstances in which rapid response investigations into unexpected child deaths have not been completed fully.

New paediatricians appointed in Warwickshire are now contracted to be trained to respond to unexpected child deaths. Training is being provided to paediatricians who are currently in post, and a procedure for the paediatric response is close to being finalised.

Additional police officers have been trained in responding to unexpected child deaths, including those on the Senior Investigating Officers rota which makes the response out of office hours. Further briefing will be provided to ensure all relevant staff are aware that this protocol covers 16 and 17 year olds.

The independent chair will write to the relevant agencies - Clinical Commissioning Groups, Police and Ambulance Service, to seek assurance that sufficient resource is now in place to carry out the statutory requirements, and that this will reliably include 16 and 17 year olds.

Finding five: In Warwickshire there is a pattern of disparate information sharing across agencies increasing the risk that important information relevant to keeping children safe will be overlooked.

Health visitors are now informing the child's GPs when a referral for statutory assessment is made. Steps have been taken to improve liaison between community midwives and health visitors, but further work is planned to align the processes in the north and south of Warwickshire for antenatal information sharing to ensure the best practices are applied

throughout the county. Consideration is being given to how this could be extended to include the arrangements with a neighbouring hospital trust providing midwifery to parts of Warwickshire.

A Multi-agency Safeguarding Hub is being developed which will support comprehensive information sharing at the point a case is referred.

WSCB will request that the newly appointed named GPs review how information is shared between health providers, and promote good connections at the interfaces.

WSCB will promote the use of CAF assessments and family support meetings as a structured forum for information sharing and planning with families when more than one agency is providing targeted support, particularly for preschool children.

WSCB will commission an audit to examine whether the participation of all relevant agencies is being sought in the lateral check stage of a referral for statutory assessment, and whether appropriate participation is being maintained in any subsequent strategy meetings, initial and review child protection conferences.